OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
FACILITIES DEVELOPMENT DIVISION ~ www.oshpd.state.ca.gov/fdd
1600 9th Street, Room 420 ~ Sacramento, California 95814 Phone (916) 654-3362 FAX (916) 654-2973
1831 9th Street ~ Sacramento, California 95814 Phone (916) 324-9090 FAX (916) 324-9145 North and Central Region
311 South Spring Street, Suite 1001, Los Angeles, CA 90013 Phone (213) 897-0166 FAX (213) 897-0168

Application for Plan Review

A

Name of Facility: E-mail:

Address - Street: Phone: FAX #:

City: County: Zip:

Name of Facility Representative/Administrator: E-mail:

Address - Street: Phone: FAX #:

City: State: Zip:

Scope of Project (45 characters max): Applicant Job #:

B

Description of Project: ❑ Geotech Only ❑ Preliminary ❑ Final

❑ **SB 1953 Mitigation Construction Project (Complete "J")**

Total Beds
Before Construction: After Construction:

C

Kind of Project: ❑ New Facility (N) ❑ Addition (A) ❑ Remodel (R)

Type of Facility: ❑ General Acute Care ❑ Skilled Nursing (SNF) and Interm. Care Facility (ICF)
❑ Psychiatric Hospital ❑ Correctional Treatment Center (CTC) ❑ Clinic

D

Legal Owner: Phone: FAX #: E-mail:

Address: City: State: Zip:

E

ESTIMATED COSTS

1. **Estimated construction cost of project** (Including Fixed Equipment, **excluding** Radiology Equipment, Design Fees, Inspection Fees, and Off Site work).....$ _____

2. **Estimated cost of Radiology Equipment** (X-ray, MRI, CT Scans, etc).....$ _____

FEES WILL BE BASED UPON: Skilled Nursing Facilities (SNF) are 1.5% (.015) of estimated cost
Acute Care Hospitals (Hosp) fees are 1.64% (.0164) of estimated cost

F

Application for Plan Review made by (Name typed):

Signature: Date:

Title: Phone #:

Address: FAX #:

City: State: Zip: E-mail:

Who is to be known as: ❑ Legal Owner/Administrator
❑ Agent for the Legal Owner/Administrator (Authorization must be attached)

OFFICE USE ONLY

OSHPD #:

Facility I.D. #:

SUBMITTAL

- ❑ Preliminary
- ❑ Field Review
- ❑ Revised Final
- ❑ Examination
- ❑ OTC
- ❑ Final
- ❑ Expedite

DISTRIBUTION

- ❑ OSHPD _____
- ❑ Project File _____
- ❑ Rad. Health _____
- ❑ L & C _____
- ❑ _____

OSHPD RECEIPT STAMP

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Application for Plan Review

G	Name of Facility (from front page)	OSHPD #

H Enclosed with this application are the following documents:

____	Plans	____	Geotechnical Reports (For New Facilities and Additions) Date sent: _____
____	Specifications	____	Testing, Inspection and Observation Program (TIO)
____	Structural Calculations	____	Verification of conformance to Local Codes (for New Facilities and Additions)
____	Equipment Anchorage Calculations	____	_____
____	Design Program (Optional)	____	_____

I **Plans and Specifications prepared by the following:** **Check discipline in general responsible charge of project** ☑

Architect – Firm ❑

Individual Responsible:			Lic. #:
		E-mail:	
Alternate:			Lic. #:
		E-mail:	
Address:			Phone #:
City:	State:	Zip:	FAX #:

Structural Engineer – Firm ❑

Individual Responsible:			Lic. #:
		E-mail:	
Alternate:			Lic. #:
		E-mail:	
Address:			Phone #:
City:	State:	Zip:	FAX #:

Mechanical Engineer – Firm ❑

Individual Responsible:			Lic. #:
		E-mail:	
Alternate:			Lic. #:
		E-mail:	
Address:			Phone #:
City:	State:	Zip:	FAX #:

Electrical Engineer – Firm ❑

Individual Responsible:			Lic. #:
		E-mail:	
Alternate:			Lic. #:
		E-mail:	
Address:			Phone #:
City:	State:	Zip:	FAX #:

Geotechnical Report – Firm ❑

Individual Responsible:			Lic. #:
		E-mail:	
Alternate:			Lic. #:
		E-mail:	
Address:			Phone #:
City:	State:	Zip:	FAX #:

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Application for Plan Review

SB 1953- Mitigation Construction Projects

J

Facility #_____
Bldg. #_____ **Bldg. Name**_____

Deficiencies Mitigated

SPC From _____ **SPC To**_____ **SPC Partial/Full**_____

NPC From _____ **NPC To**_____ **NPC Partial/Full**_____

Facility #_____
Bldg. #_____ **Bldg. Name**_____

Deficiencies Mitigated

SPC From _____ **SPC To**_____ **SPC Partial/Full**_____

NPC From _____ **NPC To**_____ **NPC Partial/Full**_____

Facility #_____
Bldg. #_____ **Bldg. Name**_____

Deficiencies Mitigated

SPC From_____ **SPC To**_____ **SPC Partial/Full**_____

NPC From_____ **NPC To**_____ **NPC Partial/Full**_____

OFFICE USE ONLY

OSHPD #:_____

_____

Region:_____

Field Review (FR) Staff:

_____

Plan Review (PR) Staff:

_____

Date:_____

(Please, duplicate page **"J"** for more buildings.)

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INSTRUCTIONS FOR APPLICATION FOR PLAN REVIEW (OSH-FD-121)

Do not write in Office Use Only area on this application.

Note: If licensure by the California Department of Health Services is not required by your facility, review by OSHPD is not required and the application is not required. Your application and plans should be submitted to local jurisdictions.

A Enter name as it appears on the facility license. Enter email address, street address, city, county, zip code phone number and fax number.

Enter the name of the Facility Representative/Administrator, email address, phone number, fax number, city, state and zip code. Copies of all correspondence will be sent to the Facility Representative/Administrator. If no Facility Representative/Administrator address is entered, copies of all correspondence will be sent to the Facility address as indicated on the license to the attention of Facility Administrator.

Plans returned for correction or stamping will be sent to the Architect or Engineer in general responsible charge of the project as indicated in Section I.

Scope of project - enter a brief (45 characters max) description statement of the work to be performed. Applicant jobs number - if the facility or architect has a numbering system for projects, enter that project number.

B Description of Project - Check whether this application accompanies a geotechnical report, preliminary report, or final plan submittal. Describe the work to be performed. Where appropriate, include square footage and quantities. Enter total bed count before construction and after construction.

C Check the kind of project. Check Type of Facility as licensed.

D Enter the name of the legal owner, address, phone, fax number, e-mail address, and street address.

E Estimated Cost

Line 1. Enter estimated construction cost of project, including Fixed Equipment to be permanently attached to the building either electrically, mechanically or structurally, but excluding all design fees, inspection fees, off-site work and radiology equipment cost.

Line 2. Estimated cost of radiology equipment. (X-ray, MRI, CT Scans, etc.)

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F This application for plan review is to be signed and dated by the legal owner or administrator of the facility or agent. If signed by the agent of the legal owner or administrator, the authorization shall be attached to this application.

Indicate in the appropriate boxes the name, signature, date, title, address, phone number, fax number, city, state, zip code, and e-mail address of the applicant.

G Enter the name of the facility from Section A on Page 1.

H Indicate the number of documents enclosed.

- Plans and Specifications - Submit one (1) set of plans and specifications for projects involving the structural frame of a health facility.
- Submit one (1) set of plans and specifications for nonstructural health facility projects or for one story, type five skilled nursing facilities.
- Submit copies of structural calculations and equipment anchorage calculations.
- The applicant may submit a copy of the design program if desired.
- Submit three (3) sets of geotechnical reports for projects involving new facilities and additions to existing facilities. If geotechnical reports were previously submitted to OSHPD, indicate the date they were sent.
- Testing, Inspection, and Observation Program (TIO)
- If verification of conformance to local is required, indicate that these are being included with the application.
- Spaces are provided for additional information or documents being enclosed with the application.

I Provide information for those disciplines which are involved in this project. Check the box for the discipline, which is in general responsible charge of this project. If plans need to be returned, they will be sent to this individual. For each discipline, provide the name of the individual in responsible charge of the project, e-mail address, his/her license number, an alternate person to contact, e-mail address, his/her license number, the street address, phone and fax number, city, state, and zip code.

J This section is only to be submitted for SB 1953 Mitigation Projects.

Provide the following information for each building in this SB 1953 Mitigation Construction Project:

- Building name and number.
- Deficiencies mitigated by this project.

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- SPC before and after construction; Partial or full Compliance.
- NPC before and after construction; Partial or full Compliance.

Full Compliance should only be chosen if this SB 1953 Mitigation Construction Project meets <u>all</u> requirements for SPC/NPC compliance for the listed Building as designated in the Compliance Plan.